DSS-EA-319 (02-98)

DEPARTMENT OF SOCIAL SERVICES
OFFICE OF ECONOMIC ASSISTANCE

ORAL/WRITTEN REQUEST FOR ADMINISTRATIVE HEARING

Date of Request: _____

Name of Person Making Request: _____

Address of Person: _____

_____

_____

Telephone Number: _____

Lawyer or Other Representative (if known): _____

Case Number: _____

Program(s): _____

Issue: _____

_____

_____

DSS Action/Date: _____

☐ **I want my benefits to continue the same as before this Notice. I understand that if I continue receiving benefits and the Department's action is upheld by the hearing decision, I will have to pay back some or all of the benefits I received while I was appealing the action.**

☐ **I want my benefits to change as indicated on this Notice. This will prevent my having to pay back benefits that I may not be entitled to receive.**

Submitted by:

_____
Caseworker

_____
Supervisor

_____
County Office

Sent to OAH: _____

***The written hearing request (if one is submitted) must be attached to this form.**